		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155794	B. WIN			11/27/	2012
	PROVIDER OR SUPPLIER			2460 G	ADDRESS, CITY, STATE, ZIP CODE LEBE ST EL, IN 46032		
	STRATFORD RETIREMENT LLC		1		L, IN 40032		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	H DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F0000	REGULATORY OR	LSC IDENTIFFING INFORMATION)		TAG	DE TELEKETY		DATE
F0000							
	This visit was for the Investigation of Complaint IN00118354.		F00	00			
	Complaint IN00118354-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282,						
	F309, and F514.						
	1509, and 1514.						
	Survey dates: November 26 & 27, 2012						
	Facility number:	011151					
	Provider number						
	AIM number:	N/A					
	Alivi humber.	N/A					
	Survey team:						
	Diana Zgonc, Ri	N					
	Diana Zgone, Ki	•					
	Census bed type	•					
	SNF: 7	•					
		23					
	Total: 30	<b>2</b> 5					
	10111. 30						
	Census payor typ	oe:					
	Medicare: 3	r <del></del>					
	Other:: 27						
	Total: 30						
	10tai. 30						
	Sample:	3					
	These deficienci	es reflect state findings					
		nce with 410 IAC 16.2.					
	ched in accordar	100 WILLI TIV II 10 IU.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

4WWT11 Facility ID:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  OF CORRECTION  155794  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 11/2	TE SURVEY  IPLETED  27/2012		
	PROVIDER OR SUPPLIER ORD RETIREMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE  2460 GLEBE ST  CARMEL, IN 46032					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Quality review completed on November 29, 2012 by Bev Faulkner, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WWT11

Facility ID: 011151

If continuation sheet Page 2 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED		
		155794	A. BUILDING		11/27/2012		
			B. WING		-		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
				LEBE ST			
STRATF	ORD RETIREMENT	LLC	CARME	EL, IN 46032			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	I	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE		
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CHA	NGES					
33-D	(INJURY/DECLIN						
		mediately inform the					
		with the resident's					
	· ·	known, notify the resident's					
		ve or an interested family					
		ere is an accident involving					
		h results in injury and has					
		equiring physician					
	intervention; a sig	nificant change in the					
	resident's physica	al, mental, or psychosocial					
	, ,	erioration in health, mental,					
	or psychosocial s						
	threatening condi						
		need to alter treatment					
		a need to discontinue an					
	_	eatment due to adverse					
	•	r to commence a new form					
		a decision to transfer or					
		ident from the facility as					
	specified in §483.	.12(a).					
	The facility must a	also promptly notify the					
	•	nown, the resident's legal					
		interested family member					
	when there is a cl	•					
		ment as specified in					
		a change in resident rights					
		State law or regulations as					
		graph (b)(1) of this section.					
	1 - 1 - 1 - 1 - 1						
	The facility must r	record and periodically					
		ss and phone number of					
		al representative or					
	interested family i	member.					
	Based on record	review and interview, the	F0157	F. 157 What corrective action	<u>n</u> 12/27/2012		
		ensure the physician was		will be taken by the facility?			
	<u>-</u>	signs as ordered and		Resident is no longer in the			
				community. How will facility	_		
		lication error according		identify other residents havir			
	to the facility pol	licy for 1 of 3 residents		the potential to be affected by			
			I .				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WWT11

Facility ID: 011151

If continuation sheet Page 3 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DAME DIVIS	A BUILDING 00		COMPLETED	
		155794	A. BUILDING	j	<del></del>	11/27/	2012
			B. WING				_
NAME OF 1	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP CODE		
					EBE ST		
STRATE	ORD RETIREMEN	IT LLC	CA	ARMEI	L, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	G	DEFICIENCY)	-	DATE
	reviewed for ph	nysician notification			the same practice and what		
	(Resident B).				corrective action will be take	<u>n?</u>	
	,				2. Every resident within the		
	Eindings includ	la.			skilled unit has the potential to		
	Findings includ	le.			affected by the deficient practi	ce.	
					Review of current skilled		
	A current facili	ty policy, dated 11/1/12,			resident's physician orders wil		
	and titled "Phys	sician Notification" and			reviewed. What measures wi		
	1	Assistant Director of			be put into place to ensure the	<u>ie</u>	
	Nursing (ADO)				<pre>recur? 3. All nurses have been</pre>	on	
	• •	Ty maleated.			in-serviced on utilizing the SB/		
	"Policy				system for physician notification		
		tion of a patient who has a			the first week of November wit		
	change in condi	ition or abnormal lab			re-education on December 4,		
	values, a license	ed nurse will perform			2012. December 4 th in-service	ce	
	appropriate clin	nical observations and data			training incorporated the Senio		
		report to physician.			Living Concepts guidelines for		
					physician notification. Nurses	will	
		r Physician Notification			be held accountable to the		
	Medication E	Error, All episodes."			guidelines through audits of		
					nursing documentation. DON,		
	The record for l	Resident B was reviewed			ADON, or RN will review at lea		
	on 11/26/12 at	10:20 A.M.			three new orders for physician		
					and family notification. Nurse	WIII	
	Diagrange for I	Dogidant D. included but			identify on phone order form, whom they notified and their o	wo	
	1 -	Resident B included but			initials in the space provided a		
	were not limited				base of order. DON, ADON, o		
	lymphoma, atri	al fibrillation, acute renal			RN will also monitor daily 24 h		
	failure, cardion	nyopathy, right lower lobe			report sheet to identify change		
	pneumonia and	MRSA (methicillin			conditions and review		
	1 ^	lococcus aureus			documentation for notification		
	bactermia).	100000us uurcus			accordingly. All in-servicing w	ill	
	Dacierilla).				be completed by 12/27/12. He		
					will the corrective action be	•	
	The resident wa	as admitted to the facility			monitored: 4. Results of the		
	on 8/31/12.				audits will be reviewed at mon	•	
					QA meetings for three months		
	On admission th	he resident had physician's			until a pattern of compliance is	3	
					established. <b>5.</b> Compliance		
Ī	orders to receiv	e Vancomycin 1.25 GM			Date: 12/27/12		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	
		155794	B. WING			11/27/	2012
NAME OF B	NOTABLE OF CLIBBLIES		S	TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u>.</u>	2460 GLEBE ST				
STRATF	ORD RETIREMENT	LLC	C	CARME	L, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	D	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		EFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T	AG			DATE
	every 24 hours b	y intravenous (IV)					
	piggyback via th	e PICC (peripherally					
	inserted central of	eatheter) line at 10:00					
	P.M.	,					
	1.141.						
	A nurses note da	ated 9/2/12 at 8:30 P.M.,					
	•	rse could not get the					
		np to work correctly. She					
	•	•					
	•	the pharmacy, but there					
		She also notified the					
	DON and was told the facility would						
	trouble shoot the	IV pump in the morning.					
	A nurses note, da	ated 9/3/12 at 12:00 P.M.,					
	indicated the Va	ncomycin had been					
	administered. The	he record lacked					
	documentation o	f what time the					
		actually administered.					
	medication was	actually dallimistered.					
	A nurses note, da	ated 9/4/12 at 2:00 P.M.,					
	•	ncomycin order had been					
	changed to 2:00	•					
	changed to 2.00	1 ,1,1,1,					
	The record lacke	ed documentation of the					
		notified of a medication					
		ident had not received his					
	ordered Vancom	ycın on 9/2/12.					
		1 1 1 1					
		ephone order, dated					
	· ·	ed 7. vital signs every					
	shift and to call t	the physician if the					
	systolic blood pr	essure was less than 90.					
	The "Vital Signs	and Weight Record"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WWT11

Facility ID: 011151

If continuation sheet Page 5 of 18

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155794		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/27/2012		
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE LEBE ST L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		ATE	(X5) COMPLETION DATE
		0/12 at 10:15 (no A.M. or a) the resident had a blood 3.					
		d documentation of ation for blood pressures					
	During an interview with the Director of Nursing (DON) on 11/26/12 at 4:30 P.M., physician notification for decreased blood pressures and the medication error were requested.						
	11/27/12 at 8:45 physician notific	iew with the DON on A.M., she indicated no ation could be found for bod pressure or the					
	This Federal Tag IN00118354.	grelates to Complaint					
	3.1-5(a)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WWT11

Facility ID: 011151

If continuation sheet Page 6 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLI	ETED
		155794	B. WIN			11/27/	2012
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
OTD ATE					LEBE ST		
STRATFORD RETIREMENT LLC		LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282	483.20(k)(3)(ii)						
SS=D	SERVICES BY Q	UALIFIED PERSONS/PER					
	CARE PLAN						
		rided or arranged by the					
		ovided by qualified					
	•	lance with each resident's					
	written plan of car			0.0			10/07/0010
		review and interview ,the	F02	82	_ F 282 What corrective		12/27/2012
	facility failed to	ensure the resident's			action will be taken by the		
	vitals signs were	monitored according to			facility? 1. The resident no		
	physician's order	rs and failed to ensure			longer lives in this community.		
	1 2	e given as ordered for 1			Licensed nurses will review ca	ire	
		•			plans for each of the skilled		
		viewed for physician's			residents. How will the facilit identify other residents having		
	orders (Resident	В).			the potential to be affected by	-	
					the same practice and what	<u> </u>	
	Findings include	· ·			corrective action will be take	n2	
					2. Every resident in the skilled		
	The record for R	esident B was reviewed			unit has the potential to be	' l	
	on 11/26/12 at 10				affected by the deficient practic	ce.	
	on 11/26/12 at 10	J.20 A.M.			Those residents with current		
					orders for vital signs will all be		
	Diagnoses for Re	esident B included, but			reviewed. What measures wi		
	were not limited	to mantel cell			be put into place to ensure the	<u>1e</u>	
	lymphoma, atrial	fibrillation, acute renal			practice does not recur? 3.		
		opathy, right lower lobe			New orders will be reflected or	า	
		MRSA (methicillin			the resident care plan		
	•	· ·			immediately or as soon as	_	
	resistant staphylo	ococcus aureus			possible following the receipt of		
	bactermia).				new orders. Nurse manageme	ent	
					will review new orders and		
	The resident was	admitted to the facility			placement of these on the care plans for two weeks. After two		
	on 8/31/12.	•			weeks if good compliance is	' l	
					achieved, the DON, ADON or F	<sub>RN</sub>	
	On 0/16/12 a ml	aviginiants talambana andan			will review one to two new order		
		nysician's telephone order			weekly to determine placemen		
	indicated the resi	-			on the care plan and nursing		
	pressure, tempera	ature, pulse and heart			knowledge of care plan entry		
	rate) should be n	nonitored every shift and			through question and response		
		~			New orders are reviewed daily	,	

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Event ID: 4WWT11

Facility ID: 011151

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		155794	B. WIN	_		11/27/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OTDATE		-110	2460 GLEBE ST				
STRATFORD RETIREMENT LLC				CARIVIE	EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	M-F, during morning stand up	DATE	
to call the physician if the systolic blood					meeting. How will the		
	pressure falls bel	low 90.			corrective action be monitored:  4. Results of the audits will be		
		d documentation of the			reviewed at monthly QA meeti	ngs	
		n the following dates:			, for three months or until a		
	_	shift. No temperature,			pattern of compliance is established. 5. Compliance		
	pulse or respirations 9/17/12 7p - 7a shift. No temperature, pulse or respirations 9/18/12 7a - 7p shift. No temperature,				Date: December 27, 2012		
					, ,		
	pulse or respirati	ons					
	9/20/12 7a - 7p	shift. No temperature					
	and a blood press	sure of 88/58, no					
	physician notific	ation					
	On 9/30/12, a see	cond physician's					
		indicated the resident's					
	_	onitored every shift and to					
		n for systolic blood					
	pressure less that	_					
	pressure ress than						
	The record lacke	d documentation of the					
		n the following dates:					
	_	shift. No vital signs					
		shift. No vital signs					
		ot known). No vital signs					
	,	signs for either shift					
		•					
	10/3/12 /a - /p s	hift. No vital signs.					
	On admission 41-	a racidant had physicianla					
		e resident had physician's					
		Vancomycin 1.25 GM					
	1	y intravenous (IV)					
		e PICC (peripherally					
	inserted central c	catheter) line at 10:00					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WWT11

Facility ID: 011151

If continuation sheet Page 8 of 18

155794	BUILDING 00	(X3) DATE SURVEY  COMPLETED  11/27/2012
155794 B.	WING STREET ADDRESS, CITY, STATE, ZIP CODE	11/21/2012
NAME OF PROVIDER OR SUPPLIER	2460 GLEBE ST	
STRATFORD RETIREMENT LLC	CARMEL, IN 46032	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI TAG DEFICIENCY)	E COMPLETION
P.M.		
A nurses note, dated 9/2/12 at 8:30 P.M., indicated the nurse could not get the resident's IV pump to work correctly. She attempted to call the pharmacy, but there was no answer. She also notified the DON and was told the facility would trouble shoot the IV pump in the morning. The resident did not receive the ordered Vancomycin on 9/2/12. The record lacked documentation of what time the medication was actually administered.  During an interview on 11/26/12 at 4:30 P.M., with the DON, the missing vital signs were requested.  During an interview on 11/27/12 at 8:45 A.M., with the DON she indicated none of the vital signs could be found and the resident did not receive the ordered Vancomycin on 9/2/12.  This Federal Tag relates to Complaint IN00118354.  3.1-35(g)(2)		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WWT11

Facility ID: 011151

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IN PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155794	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COM	PLETED 7/2012		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WWT11

Facility ID: 011151

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155794	B. WING		11/27/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	K		SLEBE ST	
STRATE	ORD RETIREMEN			EL, IN 46032	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0309 SS=G	483.25 PROVIDE CARE HIGHEST WELL Each resident means provide the services to attain practicable physical psychosocial well the comprehensicare. Based on record facility failed to educated on percatheters (PICC ensure daily PIC completed for 1 PICC line care resident to the complete of the complete of the complete of the picc of the care resident in the picc of the	E/SERVICES FOR BEING ust receive and the facility necessary care and or maintain the highest cal, mental, and Il-being, in accordance with ve assessment and plan of review and interview, the ensure nurses were ipherally inserted central ) line care and failed to	F0309	F 309 What corrective action will be taken by the facility? The resident no longer lives in this community. How will the facility identify other resident having the potential to be affected by the same practice and what corrective action with be taken? 2. Every resident of will be taken?	12/27/2012 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
	,	ein. (Resident B).		the skilled unit with a PICC line has the potential to be affected the deficient practice. The factourrently has no residents with PICC lines. What measures were seen to be sufficiently the skilled or seen and the skilled	d by cility n will
	and revised 7/1/Catheter Flushir Director of Nurs at 2:35 P.M., ind "To be Performe Licensed nurses and facility policompetent in the therapy with her The nurse shall attaining and may with infusion the			be put into place to ensure the deficient practice does not recur? 3. Each nurse is being trained or re-trained on Central Line Care and Maintenance.  Training will entail classroom return demonstration. Resider requiring PICC line care will not be admitted until training complete. All nurses hired afticompliance date will be trained utilizing training DVD prior to assignment on the floor. DON ADON or RN will observe return demonstration by nurse. Once PICC line admissions begin, Omnicare IV physician order sheets will be utilized, identifying training DVD prior to assignment on the floor.	g and nts ot er d , rn e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WWT11

Facility ID: 011151

If continuation sheet Page 11 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED	
		155794				11/27/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					LEBE ST		
STRATFORD RETIREMENT LLC			CARME	EL, IN 46032			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	1. Specific flush	orders must be			all areas of attention for the		
	documented				proper care and maintenance	of	
		performed to ensure and			PICC /central line. Flushing		
	_	_			orders read as follows: Use		
	maintain cathete	r patency			SASH technique or SAS (Use		
					saline only for valved catheters		
	The record for R	lesident B was reviewed			ports, PICCs and Central lines Continuous infusion - No flush		
	on 11/26/12 at 1	0:20 A.M.			needed. Intermittent Meds:	ıı ıy	
					Non-Valved, SASH 10 ml Norr	mal	
	Diagnoses for R	esident B included but			Saline before Med, 10ml	***	
	Diagnoses for Resident B included but were not limited to mantel cell				normal saline after Med then 5	5 ml	
					Heparin 10units/ml. Valved		
	1	l fibrillation, acute renal			Catheter (SAS) 10 ml Normal		
	failure, cardiomy	yopathy, right lower lobe			Saline before Med, 10 ml Norr	mal	
	pneumonia and	MRSA (methicillin			Saline after Med. Minimum flu	ısh	
	resistant staphyl	ococcus aureus			for unused Lumens: PICC		
	bactermia).				non-valved q 12 hours each	_	
					lumen 10ml Normal Saline the	n 5	
	The manifest	4; 44 - 44 - 45 - 45 - 11; 4			ml Heparin 10units/ml. PICC valved catheter Q week flush		
		s admitted to the facility			each lumen with 10 ml Normal	I	
		a left upper arm PICC			Saline. Clarification of which		
	line.				type, valved or non-valved will	be	
					received from the hospital prio		
	Discharge instru	ctions from the hospital			admission of new resident. Or		
	on 8/31/12 indic	_			sheet will be reviewed with		
		tine PICC line care.			admitting physician for		
	mstructions, rou	tine i ice inic care.			clarification of orders. All step		
					necessary for the proper care		
		medication orders for			maintenance of the PICC/cent		
	Vancomycin 1.2	5 GM every 24 hours to			line will be placed on the MAR		
	be infused thru t	he PICC line and to flush			q shift review and performance		
	the PICC with 1	0 milliliters of normal			How will the corrective action be monitored: 4. Each reside		
		d after administration of			admitted with PICC/Central Lin		
		Discontinue the use of			will have full audit, by the DON		
					ADON, or RN of physician ord		
	vancomycin afto	er the 9/21/12 dose.			MARs and Care Plan to ensur		
					proper clarification and		
	Review of the re	sident medical record			implementation of physician		
	lacked any speci	fic orders for flushing the			orders. Audits will be complet	ed	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 CO.			COMPL	COMPLETED	
155794			ING	-	11/27/	2012	
			B. WING	CTDEET A	DDDEGG CITY CTATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
				LEBE ST			
STRAIF	STRATFORD RETIREMENT LLC			CARME	L, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident's PICC	line when not in use.			within 48 hours of admission.		
					Results of the audits will be		
	Review of the r	resident's Medication		reported at monthly QA mee		ng	
		Record (MAR) indicated			for three months or until QA	m	
		` ′			committee determines a patter		
	1	n was discontinued on			of compliance has been established. <b>5.</b> Compliance		
		red. The MAR lacked any			date: December 27, 2012.		
	documentation	of PICC line care,			GG. DOGGHIDGI 21, 2012.		
	including flushi	ing the PICC line on					
	9/22/12, 9/23/12	2, 9/25/12, 9/26/12.					
	,	,					
	The resident rea	ceived a one time order for					
	_	1 9/27/12 and the					
	medications and flushes administered as						
	ordered.						
	The resident red	ceived a one time order of					
	Vancomycin or	n 9/28/12 and the					
		d flushes administered as					
		d Husiics administered as					
	ordered.	ordered.					
	The MAR lacked any documentation of						
	PICC line care,	including flushing the					
	PICC line on 9/	/29/12, 9/30/12, 10/2/12,					
		2 and 10/5/12.					
	Pland draws w	ere ordered on 9/24/12 and					
		PICC line was flushed at					
	that time.						
	A nurses note, o	dated 10/5/12 at 4:00					
A.M., indicated the resident was NPO (nothing by mouth) for his appointment this A.M.		I the resident was NPO					
		and, for his appointment					
	ulis A.IVI.						
Ī	1						Ì

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l l	TED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 COMPLET	COMPLETED	
155794  A. BUILDING B. WING  11/27/20	012	
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER  2460 GLEBE ST		
STRATFORD RETIREMENT LLC CARMEL, IN 46032		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE	
A hospital critical care consult note, dated		
10/5/12 at 13:46 (1:46 p.m.) indicated "		
the PICC line has been difficult to		
dislodge"		
A hospital emergency room note, dated		
10/5/12 at 14:59 (2:59 p.m.), indicated		
` * <i>'</i>		
"when they attempted to remove the PICC		
line the resident became symptomatic"		
A hospital Staff Initial Consult, dated		
10/5/12 at 23:59 (11:59 p.m.), indicated		
" A Doppler (determine blood flow		
through arteries and veins) of the area		
shows a totally occluding acute DVT		
(deep vein thrombosis) of the left brachial		
vein."		
During an interview with MD #1 on		
11/26/12 at 10:05 A.M., he indicated the		
discharge instructions from the hospital		
would be routine PICC line care and		
would not be specific. They would leave		
that up to the facility physician to specify		
what that would be. He also indicated		
routine PICC line care would include		
proper dressing change technique, flushes		
and when it would be appropriate to		
discontinue use of the PICC line.		
During an interview with the DON on		
11/27/12 at 10:30 A.M., she indicated		
there was no documentation of any		
education or inservicing the nurses for		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
		155794	B. WING		11/27/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
STRATF	ORD RETIREMEN	TLLC		LEBE ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	residents who residents who residents who residents who resident also indicate were not IV cert not remember if flush the PICC of the During an interval Administrator of she indicated not would be admitted the nurses had good During an interval MD on 11/27/12 indicated the PIC at least 2 or 3 times at least	equire PICC line care. ed some of the nurses cified and the nurses could there was an order to when not being used.			

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155794	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 11/27			
NAME OF PROVIDER OR SUPPLIER STRATFORD RETIREMENT LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	COMPLETED	
		155794	B. WING		11/27/2012		
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LEBE ST		
STRATFORD RETIREMENT LLC				EL, IN 46032			
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
		PLETE/ACCURATE/ACCE					
	SSIBLE	maintain clinical records on					
	•	accordance with accepted					
		dards and practices that					
	•	curately documented;					
		e; and systematically					
	organized.						
		d must contain sufficient					
		ntify the resident; a record assessments; the plan of					
		s provided; the results of					
		s screening conducted by					
	the State; and pro						
		review and interview, the	F05	14	F 514 What corrective action	n	12/27/2012
		ensure the documentation			will be taken by the facility?		
	•	clinical record was			1. The resident is no longer in	_	
		3 resident's reviewed for			the community. How will the		
					facility identify other residen	<u>ts</u>	
	accurate records	(Resident B).			having he potential to be		
					affected by the same practice		
	Findings include	:			and what corrective action w		
					be taken? 2. Every resident h		
	The record for R	esident B was reviewed			the potential to be affected by deficient practice. Residents of		
	on 11/26/12 at 10	0:20 A.M.			the skilled unit with orders for		
					signs have been reviewed for		
	Diagnoses for Re	esident B included but			compliance. What measures		
	were not limited				will be put into place to ensu	re	
		I fibrillation, acute renal			the practice does not recur?		
		· · · · · · · · · · · · · · · · · · ·			3. Each nurse will be in-service		
		vopathy, right lower lobe			on the timeliness of med passi		
	-	MRSA (methicillin			and physician notification. In t		
	resistant staphylo	ococcus aureus			event the equipment does not work, physician will be notified		
	bactermia).				allow for alternate plan of care		
					the interim. Senior Living		
	A nurses note da	ated 9/2/12 at 8:30 P.M.,			Community Unusual Occurren	ce	
			1		,		

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  155794	A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  11/27/2012	
AND PLAN	PROVIDER OR SUPPLIER  ORD RETIREMENT LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  indicated the nurse could not get the resident's IV pump to work correctly. She attempted to call the pharmacy, but there was no answer. She also notified the DON and was told the facility would trouble shoot the IV pump in the morning. The resident did not receive the ordered	B. WING STREET A 2460 G	ADDRESS, CITY, STATE, ZIP CODE LEBE ST EL, IN 46032  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Report will be completed in the event that medication cannot be given for whatever reason, equipment failure or delivery issues. Notification of physicia and family will be documented the form at time of report. DO ADON or RN will audit three residents weekly for timeliness	COMPLETED 11/27/2012  (X5) COMPLETION DATE  Report On N,	
	Vancomycin on 9/2/12.  Review of the medication administration record (MAR) for 9/2/12 indicated the resident received the ordered dose of Vancomycin on 9/2/12.  During an interview with the DON on 11/27/12 at 8:45 A.M., she indicated the resident did not receive the ordered Vancomycin on 9/2/12, it was 6 hours late.		medication pass for one month then three times monthly and reported to QA committee monthly meetings. How will toorrective action be monitored. DON,ADON or RN will reported finding from audits to the month QA meeting for three months of QA committee has determined pattern of compliance is established. 5. Compliance date: December 27, 2012	h <u>e</u> e <u>d:</u> ort thly until	
	This Federal Tag relates to Complaint IN00118354.  3.1-50(a)(2)				

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